STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175277	A. BUILDING _____ B. WING _____	R-C 04/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON WOODS AT ALVAMAR	1501 INVERNESS DR LAWRENCE, KS 66047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS The following citations represent the findings of a 2nd Non-Compliance Revisit.	{F 000}		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: The facility identified a census of 107 residents. The sample included 3 residents. Based on observation, record review, and interview the facility failed to revise the care plan for 1 (#201) of 3 residents sampled. Findings included:	F 280		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175277	A. BUILDING _____ B. WING _____	R-C 04/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON WOODS AT ALVAMAR	1501 INVERNESS DR LAWRENCE, KS 66047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 1	F 280		

- The annual Minimum Data Set 3.0 (MDS) dated 2/24/14 for resident #201 revealed a Brief Interview for Mental Status score of 4, indicating severe cognitive impairment. The resident required extensive assistance of 2 staff members for bed mobility, transfer, and dressing. He/she required extensive assistance from 1 staff member for eating.

The 2/26/14 Care Area Assessment (CAA) for falls revealed the resident required staff assistance with activities of daily living (ADLs) and 2 staff members for transfers.

The 2/26/14 CAA for nutrition revealed the resident lost 22 pounds in the last 180 days and he/she was accepted onto hospice services.

The care plan dated 2/26/14 regarding nutrition revealed the resident could feed him/herself.

The care plan dated 2/26/14, last revised on 3/8/14, regarding falls revealed the resident had a history of falls. The care plan also showed an intervention was added to the care plan on 3/8/14 after the resident had a fall to use a scoop mattress in his/her bed.

The nurse's note dated 3/20/14 at 7:00 P.M. revealed the resident had a non-injury fall in the shower room.

The nutritional progress note dated 3/4/14 revealed staff fed the resident for meals.

Observation on 4/7/14 at 11:22 A.M. revealed the resident sat in a broda wheelchair at a table in the locked unit dining room while staff fed him/her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175277	A. BUILDING _____ B. WING _____	R-C 04/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON WOODS AT ALVAMAR	1501 INVERNESS DR LAWRENCE, KS 66047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 2	F 280		

lunch.

Interview on 4/8/14 at 7:46 A.M. with licensed nursing staff H revealed the resident required staff assistance with feeding. He/she reported the resident had a decline around the time he/she was started on hospice services on 2/10/14 and started to need staff to feed him/her. Staff H expected the care plan to reflect that change in dining assistance. Staff H also expected the care plan to revised after each fall.

Interview on 4/8/14 at 7:52 A.M. with administrative nursing staff F revealed he/she acknowledged staff did not update the care plan regarding the resident's change in ADL needs for eating or after the resident's most recent fall. Staff F expected the care plan to be updated after each fall.

Interview on 4/8/14 at 9:03 A.M. with administrative staff G revealed the kardex and the MDS show the resident required assistance for feeding but staff failed to include it on the care plan.

Interview on 4/8/14 at 10:18 A.M. with administrative nursing staff D revealed he/she expected staff to revise the care plan after declines in ADL function and after falls.

The 7/1/2010 policy provided by the facility regarding care plans revealed the resident's care plan was periodically reviewed and revised by the interdisciplinary team at re-admission and after each assessment and with changes in condition and quarterly at a minimum.

The 10/1/11 policy, provided by the facility,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175277	A. BUILDING _____ B. WING _____	R-C 04/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON WOODS AT ALVAMAR	1501 INVERNESS DR LAWRENCE, KS 66047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 3 regarding fall management revealed a resident's care plan would be reviewed and updated with each additional fall. The facility failed to revise the care plan for falls and feeding needs for this resident with severe cognitive impairment.	F 280		
{F 323} SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility identified a census of 107 residents. The sample included 3 residents. Based on observation, record review, and interview the facility failed to prevent falls for 1 (#201) of the 3 residents sampled. Findings included: - The annual Minimum Data Set 3.0 (MDS) dated 2/24/14 for resident #201 revealed a Brief Interview for Mental Status score of 4, indicating severe cognitive impairment. The resident required extensive assistance from 2 staff for bed mobility, transfer, and dressing. He/she was not steady and required staff assistance to stabilize when moving from a seated to a standing	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175277	A. BUILDING _____ B. WING _____	R-C 04/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON WOODS AT ALVAMAR	1501 INVERNESS DR LAWRENCE, KS 66047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 323}	Continued From page 4	{F 323}		

position, moving on and off the toilet, and surface-to-surface transfers. The resident had range of motion (ROM) impairment on one side of his/her lower extremities.

The 2/26/14 Care Area Assessment (CAA) for falls revealed the resident required staff assistance with activities of daily living (ADLs) and 2 staff members for transfers.

The 2/26/14 care plan with a revision date of 3/8/14 for falls revealed the resident had a fall on 12/17/13 and an intervention was implemented for staff to use a hoyer lift (mechanical lift) for transfers.

The physician's order sheet (POS) signed 3/29/14 revealed an order with a start date of 3/12/14 for staff to use a hoyer lift with transfers.

The nurse's note dated 3/20/14 at 7:00 P.M. revealed the resident was lowered to the ground by one facility direct care staff and one hospice staff in the spa room when a transfer was attempted by staff without the use of the hoyer lift.

Review of the fall investigation for the 3/20/14 fall revealed the hospice staff failed to follow the care plan. Staff was to use a gait belt with transfers, follow the care plan, and follow the kardex. The investigation also showed hospice staff were not allowed back into the building until a meeting was help with administration of the facility and the hospice group.

Observation on 4/7/14 at 12:38 P.M. revealed direct care staff O, direct care staff P, and licensed nursing staff H transferred the resident from his/her broda wheelchair to his/her bed. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175277	A. BUILDING _____ B. WING _____	R-C 04/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON WOODS AT ALVAMAR	1501 INVERNESS DR LAWRENCE, KS 66047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 323}	Continued From page 5 staff used the hoyer lift for the transfer and the resident tolerated the transfer well. Interview on 4/7/14 at 12:48 P.M. with direct care staff P revealed the resident was a 2-4 person transfer with the lift. Interview on 4/7/14 at 12:50 P.M. with licensed nursing staff H revealed staff provided a 2-3 person assist with a lift for transfers for this resident. Staff H expected the direct care staff to follow the intervention on the care plan and kardex. Interview on 4/7/14 at 3:36 P.M. with contracted hospice home health aide (HHA) JJ revealed another HHA from the hospice group visited the resident when he/she had their most recent fall and the hospice and facility staff failed to use the hoyer lift for transfer of this resident. Interview on 4/8/14 at 9:44 A.M. with administrative nursing staff D revealed he/she expected staff to follow the care plan for transfers and cares. The 10/1/11 policy provided by the facility for fall management revealed facility staff, residents, and family members were informed of the different interventions to use with the resident through the care plan process. The facility failed to prevent a fall by not following the care plan for this severely cognitively impaired resident with a history of falls.	{F 323}		
{F 325} SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE	{F 325}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175277	A. BUILDING _____ B. WING _____	R-C 04/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON WOODS AT ALVAMAR	1501 INVERNESS DR LAWRENCE, KS 66047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 325}	Continued From page 6 Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: The facility identified a census of 107 residents. The sample included 3 residents. Based on observation, record review, and interview the failed to address the registered dietitian's recommendations in a timely manner for 1 (#201) of the 3 residents sampled. Findings included: - The annual Minimum Data Set 3.0 (MDS) dated 2/24/14 for resident #201 revealed a Brief Interview for Mental Status score of 4, indicating severe cognitive impairment. He/she required extensive assistance from 1 staff member for eating. The resident had a weight loss while not on a prescribed weight loss diet since the previous assessment. The 2/26/14 CAA for nutrition revealed the resident lost 22 pounds in the last 180 days and he/she was accepted onto hospice services on 2/10/14.	{F 325}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175277	A. BUILDING _____ B. WING _____	R-C 04/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON WOODS AT ALVAMAR	1501 INVERNESS DR LAWRENCE, KS 66047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 325}	Continued From page 7	{F 325}		

The 2/26/14 care plan for nutrition revealed the resident received a mechanical soft diet and staff read him/her the menu due to vision impairment. The registered dietitian (RD) visited the resident annually and as needed and the dietary manager reviewed his/her record quarterly and as needed.

The 2/26/14 hospice care plan revealed starting on 3/6/14 the resident received mighty shakes twice each day between meals.

The list of weight documentation provided by the facility on 4/7/14 at 10:01 A.M. revealed the following monthly weights: January 2014 equaled (=) 176.2 pounds (#); February 2014 = 168.7#; March 2014 = 163.2#; April 2014 = 152#.

The 4/1/14 RD note revealed the resident had an 11.2# weight loss since the previous month. The RD gave a new recommendation to discontinue the resident's bedtime snack and begin the supplement Resource four times each day.

The physician's order sheet (POS) signed 3/29/14 revealed the following start dates and orders: 4/30/13 a protein snack at bedtime for assist with managing blood sugar; 2/10/14 mechanical soft diet with thin liquids; 4/7/14 discontinue bedtime snack, start resource 2.0 four times each day.

The prescriber fax notification sent 4/7/14 revealed a RD recommendation to discontinue the bedtime snack and start the resource supplement.

Observation on 4/7/14 at 11:22 A.M. revealed the resident sat in a broda wheelchair at a table in the locked unit dining room while staff fed him/her lunch. The resident was served chili (of which

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175277	A. BUILDING _____ B. WING _____	R-C 04/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON WOODS AT ALVAMAR	1501 INVERNESS DR LAWRENCE, KS 66047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 325}	Continued From page 8	{F 325}		

he/she ate 5 percent (%), mandarin oranges or tangerines (of which he/she ate 0%), mashed potatoes with gravy (of which he/she ate 10%). Staff offered the resident several alternatives, including chocolate ice cream, and the resident approved. Staff then fed the resident chocolate ice cream (of which she ate 100%). Staff then offered the dessert of the day, which was cake with a scoop of vanilla ice cream (of which the resident ate approximately 50%.

Interview on 4/8/14 at 7:15 A.M. with administrative nursing staff F revealed the resident had a lot of weight loss in December 2013 and pain, so the facility discussed hospice options with the resident's family. Staff F also stated hospice services helped a lot with the resident's pain.

Interview on 4/8/14 at 8:13 A.M. with licensed nursing staff H revealed when the facility received a recommendation from the RD it was reviewed by the director of nursing or the assistant director of nursing then faxed to the physician for approval. Once the recommendation was approved staff would implement it. Staff H stated the recommendation was usually faxed to the physician the same day it was made by the RD.

Interview on 4/8/14 at 8:15 A.M. with administrative nursing F revealed staff faxed RD recommendations to the physician for approval. Staff acknowledged the recommendation made by the RD on 4/1/14 was not faxed by staff until 4/7/14. Staff F stated, " that was my fault, " and reported he/she usually sent RD recommendations to the physician sooner than 7 days.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175277	A. BUILDING _____ B. WING _____	R-C 04/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON WOODS AT ALVAMAR	1501 INVERNESS DR LAWRENCE, KS 66047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 325}	Continued From page 9 Interview on 4/8/14 at 9:44 A.M. with consultant registered dietitian EE revealed he/she was unsure of the timeframe for staff to send his/her recommendations to the physician. Staff EE reported he/she hoped it was timely enough to prevent additional weight loss. Interview on 4/8/14 at 10:18 A.M. with administrative nursing staff D revealed the facility had weekly meetings to review nutrition and the staff would have recognized the new recommendation at that time. The 6/1/07 policy provided by the facility for the supplemental nutrition program revealed staff ensured that residents at nutritional risk were assessed and offered appropriate nutritional supplementation. The facility failed to submit the RD recommendation to the physician in a timely manner for this severely cognitively impaired resident with known weight loss.	{F 325}		